

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for CPT Code 97799-CP.
- b. The request was received on April 25, 2002.

II. EXHIBITS

1. Requestor, Exhibit 1:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFA's
 - c. EOB
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit 2:
 - a. TWCC 60 and/or Response to a Request for Dispute Resolution
 - b. HCFA's
 - c. Audit summaries/EOB
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on June 20, 2002. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on June 21, 2002. The response from the insurance carrier was received in the Division on July 9, 2002. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor's representative, ____, states in the correspondence dated June 13, 2002 that... "...WOL+MED is requesting a hearing before the Medical Review Division because ____ has improperly reduced or denied payment for services rendered to [injured worker]..."
2. Respondent: The respondent states in the correspondence dated July 9, 2002 that... **"The Texas Medical Fee Guidelines list procedure code 97799 as requiring documentation of procedure and provides for reimbursement at a 'fair and reasonable rate'. ____ reimburses these services at a fair and reasonable rate of \$125 per hour for an accredited provider and \$100 per hour for an non-CARF accredited facility. According to the fee guidelines, documentation is required for services billed with procedure codes designated as DOP..."**

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on April 25, 2001 and extending through May 18, 2001. Dates of service April 18, 2001 through April 24, 2001 are outside the 365 day ruling and therefore not within the jurisdiction of Texas Workers Compensation Commission.
2. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
04/25/01	97799-CP (5)	\$900.00	\$500.00	F	DOP	MFG, MGR (II)(G)	Requestor has submitted daily treatment notes to support the services rendered as billed. Requestor has also submitted EOB's from other insurance carriers supporting payment of \$180.00 to \$185.00 per hour; therefore, reimbursement in the amount of \$4,765.00 (\$9,765.00 - \$5,000.00 = \$4,765.00) is recommended.
04/26/01	97799-CP (4)	\$740.00	\$400.00	F	DOP	CPT descriptor TWCC Rule 408.021(a)(1-3)	
04/30/01	97799-CP (4)	\$740.00	\$400.00	F	DOP		
05/01/01	97799-CP (4)	\$740.00	\$400.00	F	DOP		
05/02/01	97799-CP (4)	\$740.00	\$400.00	F	DOP		
05/03/01	97799-CP (3)	\$540.00	\$300.00	F	DOP		
05/04/01	97799-CP (4)	\$740.00	\$400.00	F	DOP		
05/07/01	97799-CP (4)	\$740.00	\$400.00	F	DOP		
05/08/01	97799-CP (4)	\$740.00	\$100.00	F	DOP		
05/09/01	97799-CP (4)	\$740.00	\$400.00	F	DOP		
05/10/01	97799-CP (4)	\$740.00	\$400.00	F	DOP		
05/16/01	97799-CP (3)	\$555.00	\$300.00	F	DOP		
05/17/01	97799-CP (3)	\$555.00	\$300.00	F	DOP		
05/18/01	97799-CP (3)	\$555.00	\$300.00	F	DOP		
Totals		\$9,765.00	\$5,000.00				The Requestor is entitled to reimbursement in the amount of \$4,765.00

The above Findings and Decision are hereby issued this 2nd day of January 2003.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$4,765.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

This Order is hereby issued this 2nd day of January 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

MF/mf